MARYLAND COMMISSION ON KIDNEY DISEASE

THE CONNECTION

VOLUME 7 ISSUE 1 APRIL 2008

MESSAGE FROM THE CHAIRMAN

Every freestanding dialysis facility must be staffed by a multidisciplinary team of highly skilled medical and administrative personnel. The medical director, however, has the unique role of supervising all required standards of care and basic facility operating procedures which are implemented by the dialysis health care team. By analogy, the medical director is like the "captain of the ship" at the facility and has tremendous overall responsibility to ensure patient safety and quality of care. The Federal and State regulations contain a lengthy list of regulations that apply to the functions of the medical director. Many of the defined functions are supervisory in nature, such as the development of policies and procedures regarding administration of therapeutic medications, monitoring dialysis water standards and adequacy of dialysis. Other functions include the active participation in the facility's quality assurance and improvement program. The medical director must monitor the professional care provided by treating physicians and professional staff in the facility. Physicians must be credentialed and round on their patients at least monthly. The dialysis professional staff requires proper training, education and guidance to perform their jobs in a safe and effective manner. Additionally, the medical director has the responsibility to implement the legally required written policies of the facility. Finally, the medical director must monitor various situations that affect enforcement of facility policies to provide safe care to all dialysis patients. As a medical director of a freestanding dialysis facility for more than 25 years, my own experiences have taught me that it is essential to maintain open and frequent communication with facility staff in order to perform my job effectively. The earlier I am apprised of a real or potential problem, the easier it is for me to become part of its solution. Through telephone communication with key facility personnel, monthly quality assurance and improvement meetings, ongoing staff and patient education, and active enforcement of our facility policies, it is possible to prevent the routine small problems from spiraling out of control.

Most medical directors of dialysis facilities in Maryland are compliant with the dialysis regulations and successfully help provide patients with high quality medical care. The Kidney Commission recognizes that to be a medical director requires a clear understanding of numerous regulatory requirements as well as the ability to act on the myriad of medical and legal responsibilities that come with the position. The Kidney Commission is always available to assist medical directors in problem solving should the need arise.

By: Roland Einhorn, M.D., Chairman

COMMISSION MEETINGS

The Commission on Kidney Disease will be meeting on the following dates in 2007:

April 24, 2008

July 24, 2008

October 23, 2008

The Commission meets at the Department of Health and Mental Hygiene, 4201 Patterson Avenue Baltimore, MD 21215. The Open Session of the meeting begins at 2:00pm and is open to the public. For further information regarding these meetings, please contact the Commission office at (410) 764 4799.

INSIDE THIS ISSUE:

COMMISSION NEWS

NEWLY APPOINTED MEMBERS

- **Kulwant Modi, M.D.**
- **Kimberly Sylvester, RN, MS**

PATIENT EDUCATION REGARDING DIALYSIS ACCESS CARE

The Center for Disease Control (CDC) is currently reviewing dialysis patient deaths via exsanguination. Their investigators have determined that the rate of deaths in Maryland is higher than other states in the US. In 2007 the Department of Health and Mental Hygiene sent out the *Life Threatening Vascular Access Hemorrhage Prevention Statement and Important Information for Hemodialysis Patients* sheet to each dialysis facility. The Commission requests that dialysis healthcare professionals identify patients at risk and assist them to access care and educate patients on access care including instructions on what to do if the access starts bleeding at home.

MARYLAND BOARD OF NURSING

In the Fall of 2007, The Maryland Board of Nursing in cooperation with the Office of Health Care Quality and the Commission on Kidney Disease published "Frequently Asked Questions: End Stage Renal Disease (ESRD) Setting". This publication was mailed to each dialysis facility administrator and is also available on the Commission's website: www.mdckd.org. The Commission encourages every dialysis nurse and technician to review this information.

CITATION FREE SURVEYS

The Commission is commending the following citation free facilities:

- Montgomery Renal Center
- Renal Care of Bowie
- Renal Care of Seat Pleasant

It is an achievable goal, and should also be the goal of each facility in this New Year. CONGRATULATIONS for a job well done!

HEPARIN ISSUE

Heparin is commonly utilized in dialysis facilities to prevent the clotting of dialyzer fibers during hemodialysis. Recently this drug has been in the spot light in reference to drug administration errors, labeling issues and recalls. The Maryland Board of Nursing recommends that each facility have in place a mechanism to verify the correct dosage from the correct vial of heparin prior to the administration of the drug.
The CNA-DT may draw up medication from a multidose vial when the order specifies the number of cc's to be drawn up from the vial and when the medication concentrate is also specified (e.g. administer 2000 units of Heparin – 2 cc from a 1:1000 unit vial). However, as noted above, the dosage should be verified with another staff member prior to administration.

REVIEW OF FACILITY DRAWINGS

Howard Jones, Principal Engineer for the Office of Capital Planning, Budgeting and Engineering Services, is available to review dialysis facility drawings for new facilities and expansions. The Commission and the OHCQ encourages facilities to utilize Howard's expertise in this area. His phone number is 410 767 5926.

COMMISSION WEBSITE

www.mdckd.org

Find the latest Commission information: meeting dates, new facility information, complaint forms, regulations, Governor's report and past and current newsletters.

TRANSPLANT NEWS

The Commission's Transplant Committee has compiled transplant information to create the *"Transplant Liaison Resource Manual: Resources for Transplant Education, Evaluation, Referral, Patient Status Changes and Submission of Laboratory Samples"*. This manual was mailed to each dialysis facility in the fall and is also available online @ http://ww.mdckd.org.

FACILITIES APPLYING FOR CERTIFICATION

The following facilities have applied for certification with the Commission, for KDP reimbursement purposes:

Davita – Aberdeen

IDF – Garrett Center

Davita – Seton Drive

The above stated facilities have been certified and are in good standing with the Commission.

REGARDING VIOLENT & ABUSIVE PATIENTS

Early Intervention Encouraged for Violent & Abusive Patients:

In the realm of outpatient dialysis care, an unfortunate but true reality is that facilities can be faced with caring for violent and abusive patients. While the safety and security of the dialysis facility is paramount, there are strategies that the Commission encourages you to employ when dealing with patients of this nature. Violent and abusive patients pose a unique problem within the field of Chronic Kidney Disease as renal replacement therapy is required to sustain life. Failure to manage violent and abusive behaviors may result in discharge from the dialysis clinic which poses risk to the patient for eventual death due to lack of access to care. The onset of Stage V Chronic Kidney Disease and need for renal replacement therapy can lead to feelings of loss of control, which can result in exacerbation of violent and abusive outbursts due to poor coping skills. Research supports that violent and abusive behaviors generally follow a trajectory of increasing lethality unless intervention occurs early.

The Commission recommends that each outpatient facility practice early intervention when it comes to patients with violent and abusive actions. Referrals to the unit social worker should occur immediately, quickly followed by a mandatory team meeting with the patient to address these issues, to set expectations for behavior in the unit, and to set boundaries and consequences regarding outbursts. A well-written behavioral contract, with patient input, is an instrumental tool. Lastly, involving the Commission early on in your efforts to manage patients of this nature will allow the Commission to partner with you in these difficult situations, with oversight, guidance and direction.

By: Anne Marie Soltis, LCSW-C

SOCIAL WORK AND DIETITIAN COVERAGE

The Commission has noted an unusual number of facilities with citations regarding the lack of dietitian and social work services provided to dialysis patients. Federal and State regulations require that dialysis facilities provide these services to their patients. In many instances the facility's dietitian or social worker may be out of the facility for prolonged periods of time. The facility may also be without dietitian or social work coverage when the dietitian or social worker's employment relationship with the facility ends.

Each facility must assure adequate nutritional and social work coverage. It is not appropriate for another facility's dietitian or social worker to "cover" patients from a sister facility without that staff member (dietitian or social worker) coming on-site to regularly meet with patients and provide required documentation. It is very important that these individuals discuss their interim role with the patients and be available while the facility is awaiting the return or hire of the dietitian or social worker.

KIDNEY DISEASE PROGRAM OF MARYLAND

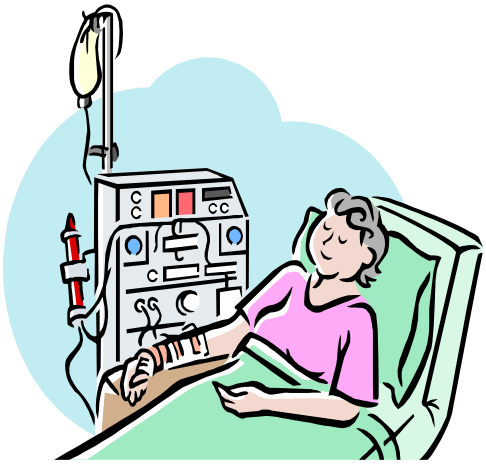
In Fiscal Year, 2007, the Kidney Disease Program provided coverage to approximately 2325 beneficiaries. KDP net expenditures for FY 2007 totaled $10,503,399. The KDP recovered $335,219 in premiums and $1,255,177 from its Drug Rebate Program in FY 2007. These recoveries are projected annually and are incorporated into the Program's reimbursement budget.

The Kidney Disease Program (KDP) has been diligently working on trying to accomplish successful implementation of the electronic claims management system (eCMS) which electronically processes claims of all service types. The Kidney Disease Program has developed and transitioned its point of sale (POS) system for the payment of pharmacy claims to ACS. These systems allow KDP to accept and return HIPAA compliant transactions from Medicare trading partners and all participating providers. Enhancements and system developments continue in an effort to provide more efficient and timelier processing of claims.

The Kidney Disease Program has developed and implemented the necessary changes needed to utilize the National Provider Identification (NPI) number on all electronic and paper claim forms.

The Kidney Disease Program worked with and continues to notify all ESRD recipients certified with the Program to apply for Medicare Part D prescription coverage, as required by House Bill 697.

Customer service in the area of patient certification continues to generally meet standards. KDP personnel strive to assist KDP recipients, in processing applications as quickly and efficiently as possible and provide education to members of the renal community to assist them in receiving the most accurate information possible.



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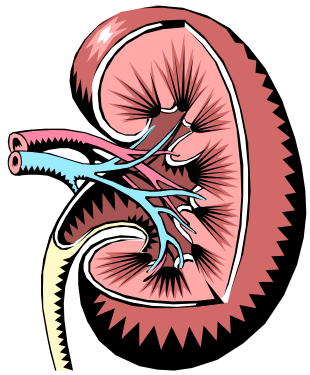
4201 PATTERSON AVENUE
BALTIMORE, MARYLAND 21215
TOLL FREE : 1 866 253 8461
TEL: (410) 764 4799
FAX: (410) 358 3083
EMAIL:schwarte@dhmh.state.md.us



WE ARE ON THE WEB

HTTP://WWW.MDCKD.ORG

PATIENT ADVOCACY GROUP

Cancer, the 2nd leading cause of death in ALL transplant recipients - How to Change this Reality

As early as the late 1950s Dr. Israel Penn, founder of the Israel Penn International Tumor Registry recognized the role immunosuppression plays in causing cancer in transplant recipients. Not only are transplant recipients at high risk for cancer but to a lesser degree are those on hemodialysis. Dr. Penn reported that cancer in the immunosuppressed occurred 20-30 years earlier than in the general population. While in the general population the American Cancer Society (ACS) relies on age to identify when to commence cancer screening in the immunosuppressed population AGE CANNOT be A DETERMINANT and has NO PLACE in cancer screening this population. With studies showing that cancer is diagnosed as early as the first year post transplant cancer screening must commence from the moment studies show cancers occurring in years 1, 2, and 3 increasing in incidence the longer the patient is immunosuppressed.

Several prominent transplant professionals have endorsed the manner of cancer screening set forth by Drs. Walters and Covinsky in screening the elderly. Drs. Bryce Kiberd among others, supports the need to screen transplant recipients based on INDIVIDUALIZED CRITERIA. Dr. Gabriel Danovitz in his editorial "On the Firing Line" commended Dr. Kiberd for taking the renal community to task for encouraging the use of the American Cancer Society Guidelines in this population. In the case of the second most common and lethal cancer in this country, colorectal cancer, the Society for Surgery of the Alimentary Tract in a 30 year retrospective took the transplant community to task for using the guidelines that the American Transplant Society put together in 2002 stating that 25% of colorectal cancers were missed using those guidelines. Basing cancer screening on AGE has not place in screening the immunosuppressed population. Additionally the American College of Gastroenterology recently suggested that African American males be screened for colon cancer earlier than the general population.

The National Kidney Foundation has formed a Malignancy Advisory Board after reviewing a survey they conducted on what transplant patients knew and did not know about their cancer risk. The results showed that they knew very little about their risk of cancer post transplant; they would have wanted to know of the increased of cancer post transplant and to include that fact in their healthcare decision.

In closing it is penny wise and pound foolish to spend $200,000 to $500,000 to implant the Gift of Life in a patient, knowingly setting in motion, by virtue of prescribing transplant drugs, a ticking time bomb that will potentially initiate a malignancy that will take that patient's life, a life fought long and hard to save from end stage disease. By implementing cancer screening beginning the first year post transplant and every year thereafter the patient will have a chance to prevent the preventable, to successfully treat that which has a chance of cure when caught at an early stage. To do anything less would be unethical.

Pearl Lewis
President